Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2020	2020_814501_0006	012361-20, 013175-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Rouge Valley
551 Conlins Road TORONTO ON M1B 5S1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 17, 21, 22, 23, 2020.

During this inspection the following complaint intakes were inspected:
Log #012361-20 related to pain management
Log # 013175-20 related to dignity, choice and privacy

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Directors of Care, physician, registered nurses, registered practical nurses, personal support workers, substitute decision-makers and residents.

During the course of the inspection, the inspector conducted observations of staff and resident interactions and the provision of care, reviewed health records, home's investigation notes, notes from the hospital, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of residents to give or refuse treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent was fully respected and promoted.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #002's substitute decision-maker (SDM) regarding an incident where the resident was having a change of condition. The SDM indicated that when they were called regarding resident #002's status they wanted to see the resident. A visit did take place which is when the Administrator of the LTCH claimed the resident became exposed to visitors who had not been screened for an infectious disease. This then prompted the LTCH to test the resident for the infectious disease. The SDM stated they were never asked to consent to this test. According to the SDM, resident #002 cannot communicate to the staff.

A review of resident #002's record indicated that a change of status was suspected as mentioned above and an unplanned visit took place. Progress notes indicated the resident was given a test for an infectious disease which came back negative.

An interview with RN #104 indicated that even though resident #002 can communicate, they will call the SDM to obtain consent for changes in the plan of care. RN #104 stated resident #002 did not resist getting the above mentioned test but indicated they did not receive consent from the SDM for such a test.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 with an effective date of June 10, 2020, states long-term care homes must conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms related to an identified infectious disease. Residents with symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for the infectious disease. The directive does not include direction to override the resident's right to consent.

A review of the LTCH's policy titled "Informed Treatment Consent" #RC-04-01-03 last updated June 2020, states that if a resident is not capable, the team should obtain informed consent from the resident's SDM.

The licensee failed to ensure the LTCH received consent for resident #002 to receive an infectious disease test. [s. 3. (1) 11. ii.]

Issued on this 11th day of August, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.